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ABSTRACT

With greater and greater interest in prevention activities by teachers and counselors, a strategy for systematic development and implementation of preventive intervention was developed based on George Albee's work. It includes these 10 steps: (1) describe in writing the population for whom you wish to plan a prevention intervention; (2) list the organic factors (illnesses, health habits, etc.) that can play a role in causing emotional or behavioral problems in this population; (3) list the social and environmental stress events and circumstances that are likely to impinge on the lives of people in this population; (4) list sources and kinds of exploitation that may occur in the lives of people in this population; (5) list the skills/attitudes that will help this population cope with, and grow in, their particular life situation; (6) list the actions that will help build the self-esteem of each person; (7) list the types of support systems and specify the role of each in promoting the coping, growth, and self-esteem of members of this population; (8) specify two goals and accompanying objectives for decreasing the organic factors, reducing the stress factors, and eliminating the exploitation in this population; (9) specify objectives and goals for increasing the coping skills, building self-esteem, and developing appropriate support groups for this population; and (10) explicate a strategy for the evaluation of this primary prevention plan and for follow-up with members of this population. A 28-item bibliography, a supplemental bibliography for each step, and worksheets are attached. (ABL)

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A TEN-STEP MODEL FOR TEAM PLANNING FOR PRIMARY PREVENTION

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Abstract

With greater and greater interest in prevention activities by teachers and counselors, a strategy for the systematic development and implementation of preventive intervention was developed. Based on Albee's incidence formula, this paper presents a ten-step model by which individual counselors and teachers or groups of teachers, counselors, and community members, as well as families, corporations, congregations, and communities, can deliberately and systematically develop and implement a preventive intervention. An extensive bibliography and collection of worksheets is included.

Introduction

In a major contribution to The Counseling Psychologist, Whiteley (1980) characterized counseling psychology's traditional approach as "reactive" (p. 3), and he predicts that by the year 2000 A.D. the profession will progress to one that is much more proactive. In the same issue, Krumboltz and Menefee (1980) state that in the future,

> Preventive or early-intervention counseling will grow. As counselors attempt to attain their performance objectives, they will recognize the advantage of early intervention and of its logical extension, prevention. This will lead counselors to focus on identifying and altering the environmental determinants of problem behavior in their field settings. Academic and social environments will be altered to promote more desirable consequences when such environments are found to contribute to problems in the client population. (p. 47)

This article is an outgrowth of these predictions and of an honest interest in creating mentally healthy persons rather than continually remediating those who suffer from personally- and/or environmentally-determined disorders.

This ten-step procedure for the planning of primary prevention interventions has its base in the work of George Albee, a University of Vermont psychologist. In an early work (Albee, 1959), he found himself gathering information on the needs and resources in the area of mental health, and as he states,

> I came face to face with a very real problem. The number and distribution of persons with serious emotional problems in our society were far beyond what our resources, in terms of both personnel and institutions, could deal with on a one-to-one basis. The gap was so wide as to be impossible ever to bridge. (Albee, 1983, p. xi).

> Every assessment of the distribution of disturbance in the society arrives at an estimate of approximately 15 percent of the population. In addition to this number of "hard-core cases," each year there is a much larger number of people experiencing intense life crises. And when we realize that in any given year only about 7 million separate persons are seen throughout the entire mental health system, both public and private, we can begin to appreciate the hopelessness of our present efforts. (Albee, 1983, p. xi)

Faced with these facts, Albee (1983) admits that he had to look beyond the current types of treatment, and he found an alternative in the concept and practices of primary prevention. As he says,

> I became convinced of the logic of the public health dictum that holds that no mass disorder afflicting humankind is ever eliminated or brought under control by attempting to treat affected individuals, or by attempting to train individual practitioners in large numbers. (Albee, 1983, p. xi)

Primary prevention, as portrayed by the public health movement, is really only part of this view for the reduction of cases of an illness. Within this conceptualization, there is primary, secondary, and tertiary prevention.

> Tertiary prevention closely parallels traditional approaches. The focus is on the individual who has an established disorder, and the goals are to reduce the residual effects of it and to rehabilitate the individual to a level where he or she may readjust to community life. (Felner, Jason, Moritsugu, & Farber, 1983, p. 5)

At the next level, secondary prevention

> ...efforts are characterized by attempts at early identification and intervention with individuals who are displaying initial signs of disorder, but for whom it is not yet ingrained. Zax and Spector (1974) caution that it may be argued that early detection and effective treatment of mental disorder in an individual may be little more than what has long been viewed as good mental health care. (Felner, Jason, Moritsugu, & Farber, 1983, p. 5)

And, at the primary level, the goals of intervention

> ...may be broadly subsumed under the heading of either (1) the reduction of new cases of disorders or (2) the promotion of health and building of competencies as protection against dysfunction. (Felner, Jason, Moritsugu, & Farber, 1983, p. 5)

Depending on the population, the plan for prevention may not actually be aimed at the "primary" level, but it still strives at preventing the occurrence of additional cases of the disorder.

The nature of the primary prevention effort is contained in The Report of the Task Panel on Prevention of the President's Commission on Mental Health (Task Panel on Prevention, 1984), and it consists of four very distinct characteristics:

> (1) Most fundamentally, primary prevention is proactive in that it seeks to build adaptive strengths, coping resources, and health in people; not to reduce or contain manifest deficit.

(2) Primary prevention is concerned about total populations, especially including groups at high risk; it is less oriented to individuals and to the provisions of services on a case-by-case basis.

(3) Primary prevention's main tools and models are those of education and social engineering, not therapy or rehabilitation, although some insights for its models and programs grow out of the wisdom derived from clinical experience.

(4) Primary prevention assumes that equipping people with personal and environmental resources for coping is the best of all ways to ward off maladaptive problems, not trying to deal (however skillfully) with problems that have already germinated and flowered. (pp. 8-9)

The basis of the ten-step model used in this article is Albee's incidence formula. In this formula, Albee (1982, 1985) states that the occurrence of mental illness is related to six components:

$$\text{Incidence} = \frac{\text{Organic Factors} + \text{Stress} + \text{Exploitation}}{\text{Coping Skill} + \text{Self-Esteem} + \text{Support Groups}}$$

Within the formula, organic factors are defined as disease states, disease causes, or behaviors that contribute to disease or illness (e.g., smoking, drinking of alcoholic beverages, poor nutrition, excessive use of caffeine, drug abuse, poor sleeping habits, etc.). Stress is conceptualized as sources of threat, feelings of powerlessness, and excessive demand on personal resources, and reduction of stress "...requires changes in the physical and social environments" (Albee, 1982, p. 1046). Exploitation represents the use or abuse of someone for another's selfish advantage. Coping skills are social and cognitive abilities that enable an individual to deal with life's problems and, as a result, "...reduce the incidence of frustration and emotional disturbance" (Albee, 1982, p. 1047). Self-esteem is an individual's level of valuing of him/herself. This can be positively influenced by a person's coping abilities and by his/her support system. And, support groups are those individuals, and/or formal or informal groups of individuals, who comprise a person's external source of self-esteem, coping, and growth. Obviously, from the formula, if a reduction in organic factors, stress, and/or exploitation occurs in a person's life, then the incidence of mental illness/emotional disturbance will decrease. Likewise, if an increase in coping skills, self-esteem, and/or support groups can occur, then the incidence will also decrease. From a mathematical and practical point of view, the reduction of any component of the numerator will have positive effects, as will the enhancement of any component of the denominator.

After realizing the power in the preceding incidence formula, it is appropriate to look at the concept and practice of group planning for primary prevention. Support for use of a group in planning comes from several points:

1. Groups, rather than individuals, make better decisions and choices, because they can take more perspectives into consideration.

2. Use of groups from within a community can create ownership in the plan and increase the likelihood that it will be a successfully implemented.

3. When group members understand the concept of primary prevention and the components of Albee's formula, there is a higher likelihood that they will implement the plan with enthusiasm.

4. Groups that have representation from the local community (school, institution, or actual community) will begin to insure that local needs addressed.

In addition, these points are supported by Davis (1982) as he states

> Participation in intervention design by members of the population providing the focus for change may assist in assuring that interventions reflect local diversity. (p. 431).

Thus, the ten-step process is a combination of the Albee formula and the belief that group planning can combine to produce a meaningful and legitimate intervention intended to reduce the incidence of some problematic situation in a given community, whether that community be as small as a family, or larger such as a classroom, or even larger as in a school or congregation or business, or even in a large community. Finally, the ten-step process follows the directives of Bond and Compas (1989) who state that

> Sound and systematic efforts to prevent a variety of learning, emotional, and behavioral problems in school-aged children and youth depend on two general factors: (1) a strong theoretical model to guide research and program development; and (2) the use of rigorous methods to measure and evaluate the effectiveness or such programs. A theoretical model should determine the goals of the intervention program and the methods used to achieve these goals. Appropriate evaluation methods are essential to determine whether goals are met and to identify areas for continued program growth and development. (p. 11)

The Ten-Step Format

STEP I

DESCRIBE IN WRITING THE POPULATION FOR WHOM YOU WISH TO PLAN A PREVENTION INTERVENTION.

The process of definition will be easier if the following questions are answered:

1. Who, specifically, is the group that is to be the target of the intervention?
2. What are all the characteristics of this group?

However, before answering these specific questions, a very serious needs assessment might be attempted. In the case of a desire to work with children, it might be helpful to consider Baker and Shaw's (1987) definition of "at risk", for

> To be at risk means that a particular child or group of children presently faces a situation that holds potential for disrupting, delaying, or otherwise interfering with normal learning or development. This negative potential may be inherent in the family situation, the school setting, or the broader social structure in which the child lives. (p. 191)

Here, Baker and Shaw (1987) stress the importance of having a purpose or reason for identifying children who are at risk, and they point to specific characteristics that might lead a preventive intervention (See Table 1).

Table 1
Major Purposes of Assessment in Primary Prevention

Identification of Specific Children at Risk	**Identification of Ineffective Adults (Parents/ Teachers)**	**Identification of Nonfacilitative Environments**
LACK OF Development Social skills Learning skills Self-management skills Positive self-perception	LACK OF Behavior management skills Group management skills Disciplinary skills Communication skills Stress management skills KNOWLEDGE DEFICITS Child development Child rearing	RATE OF School failure Drop-out Truancy Absence Vandalism/delinquency Drug use
SPECIFIC LIFE EVENTS Death Divorce Abuse/neglect Serious illness/accident General lack of support network		Teacher perceptions of school Child perceptions of school

Source: Baker, S.B., & Shaw, M.C. (1987). Improving counseling through primary prevention. Columbus, OH: Merrill, p. 193.

And, in Table 2, Baker and Shaw (1987) point out formal and informal strategies for use in assessment and identification.

Table 2
Baker and Shaw's Ways to Identify at Risk Children

Identifying Specific Children at Risk	Identifying Ineffective Adults (Parents/ Teachers)	Identifying Nonfacilitative Environments
FORMAL ASSESSMENT	FORMAL ASSESSMENT	FORMAL ASSESSMENT
Kindergarten screening	Flanders Interaction Analysis	Child perceptions of school
Sociometry	Carkhuff communication scales	Teacher perceptions of school
Self-concept scales		
Observation		
INFORMAL/ ANECDOTAL	INFORMAL/ ANECDOTAL	
Teacher or parent report	Signs of stress	
	General consensus regarding teachers' effectiveness and frequent class management problems	
	General consensus regarding parents whose prior children have had problems	
	USE OF RECORDS	
USE OF RECORDS	Excessive absence	USE OF RECORDS
Declining attendance	Excessive referrals for...	Rate of...
Declining achievement	behavioral problems	School failure
Increasing problem behavior	disciplinary problems	Drop-out
Discrepancies between ability and achievement	special education consideration	Truancy
	retention	Vandalism
		Delinquency
		Drug use

Source: Baker, S.B., & Shaw, M.C. (1987). Improving counseling through primary prevention. Columbus, OH: Merrill, p. 194

The objective of this step is to clearly delineate a target population for the intervention and to identify at least some of the characteristics that are of concern.

STEP II

LIST THE ORGANIC FACTORS (ILLNESSES, HEALTH HABITS, ETC.) THAT CAN PLAY A ROLE IN CAUSING EMOTIONAL OR BEHAVIORAL PROBLEMS IN THIS POPULATION.

In completing STEP II, it will be helpful if the following questions are dealt with in a systematic manner:

1. What are the physical health habits (i.e., substance abuse, smoking, lack of exercise, lack of sleep, etc.) that may contribute to wear and tear on the bodies of the specified group?
2. What are the dietary trends/habits (poor nutrition, excessive caffeine, excessive sugar intake, excessive fat intake, etc.) that may contribute to wear and tear on the bodies of member of the specified group?

Here, it can be assumed that organic factors are disease states, disease causes, or behaviors that contribute to disease or illness. Completion of this step will assist in the development of goals, objectives, and procedures for STEP VIII.

STEP III

LIST THE SOCIAL AND ENVIRONMENTAL STRESS EVENTS AND CIRCUMSTANCES THAT ARE LIKELY TO IMPINGE ON THE LIVES OF PEOPLE IN THIS POPULATION.

There are numerous kinds of stressors and many kinds of stress. Stressors are sources of threat, situations that precipitate feelings of powerlessness, and excessive demands on personal resources. Individuals are susceptible to various kinds of stress depending on their unique personality. Some of the kinds of stress are:

Frustration stress. Goal blockage - cannot accomplish our goals for some reason. Set goal/cannot reach.

Overload stress. Too many things, not enough time.

Deprivational stress. Boredom type - underemployment - bored with job.

Type A stress. Intense about the time - achiever - must achieve all the time. Overworks, aggressive.

Psychological stress. Anxiety reactivity - getting anxious about being anxious.

Stress from being a pleaser. Significance comes from pleasing others. (Source is unknown.)

In addition, there are a number of specific kinds of stressors that my affect persons at given ages. In Table 3, Arnold (1990) presents stressor categories and examples of stressors for children and adolescents:

Table 3
Sampling of the Range of Child and Adolescent Stressors

Category of Stress	Examples
Physical	Accidents Battering Biological clock disruption by electric lights, variable schedules Iatrogenic stress: shots, rectal exam, sutures Premature contact sports Some types of sexual abuse
Chemical	Adulteration of food Fetal alcohol syndrome Insecticides, solvents Lead, other heavy metals Nicotine exposure (fetus or nursing) Other drugs
Biological	Disability, handicap Genetic vulnerability as narrowing life options Infection Other illnesses Malnutrition Puberty
Psychological	Absence of parent: illness, depression Catastrophe Deprivation Excessive television, media violence Iatrogenic stress: interviews about abuse, psychotherapy, hospitalization Legal majority Loss of parent: death, divorce Sexual and emotional abuse Threats, fears of violence
Socioeconomic/ Cultural	Competition Discrimination Future shock Poverty, unemployment Social role contradictions Threats in school and neighborhood Traditions of domestic violence "Working" parents

Source: Arnold, L.E. (1990). Stress in children and adolescents: Introduction and summary. In L.E. Arnold (Ed.), Childhood stress (pp. 1-19). New York: John Wiley, p. 3.

In addition, Arnold (1990) points out that there are two sources of stress, psychological (including social) and biological (including chemical and physical), and there are various responses to these sources. There can be psychological and/or biological (psychosomatic) responses to psychological stress, and there can be psychological (somatopsychic) and/or biological responses to biological stress (p. 5).

Heller, Price, Reinharz, Riger, and Wandersman (1984) cite findings that there are many other kinds of stressor or stressful circumstances. From the work of Holmes and Rahe (1967), they note that "stress may occur because of life changes which are simply a result of maturation across the life cycle" (p.151). They also point to Dohrenwend (1978) who believes that the level of stress a person experiences may be a result of characteristics of the person or of that person's environment, and this is illustrated as follows:

> Losing a job because one is chronically late to work is likely to be a different experience than losing a job because a plant goes out of business. While the extent of actual control over events varies, perceived control may vary, too. The chronic latecomer sometimes blames the boss instead of himself or herself for the job loss. (Heller, Price, Rienharz, Riger, & Wandersman, 1984, p. 154)

In addition, they mention the theory of Kobasa (1982) in which

> Her research assumes that a "person's general orientations toward life or characteristic interests and motivations would influence how any given stressful life event was interpreted and dealt with and, thereby, the event's ultimate impact on the physiological and biological organism" (p. 6). She has identified a personality style of stress resistance or hardiness composed of three factors. Commitment to self and others and to one's work and interpersonal relationships provides a sense of community and purpose to life that buffers the harmful effects of stress. Belief in control leads one to interpret events as stemming from one's own actions, and, therefore, as subject to influence and modification, while challenge is an orientation that welcomes change as a natural part of life and a source of opportunity rather than threat. The hardy personality, incorporating aspects of commitment, control, and challenge, is less likely to become ill when faced with stressful life events. (Heller, Price, Rienharz, Riger, & Wandersman, 1984, p. 154)

It is also mentioned in their work that "...relatively minor but irritating daily hassles, such as traffic jams or losing things or too many interruptions, also have a impact on health independent of life events" (Heller, Price, Rienharz, Riger, & Wandersman, 1984, pp. 154-155). and, finally, they point to the work of Catalano (1979) and his

> ...claims that the level of stress experienced by a population over time can be predicted by the age profile of the population and the prevailing economic conditions. He divides the list of stressors included in the life-events scale [(Holmes & Rahe, 1967)] into three categories: life-cycle events, economic well-being, and random occurrences. The random occurrence events, such as death of a family member or personal illness, remain relatively constant over time for a population and form a "baseline" level of stress. The age profile of the population would indicate the frequency of life-cycle events, such as leaving home or being married, while fluctuations in the economy would predict the rate of financial stressors, such as unemployment or a new mortgage. Such estimates of rates of health and behavioral problems could be used for social planning and policy development. (Heller, Price, Rienharz, Riger, & Wandersman, 1984, p. 155)

It is also emphasized by Heller, Price, Rienharz, Riger, and Wandersman (1984) that such environmental conditions as high population density, air pollution, heat, noise, and toxic chemicals "...have been found to affect performance, physical and mental health, and interpersonal behavior" (p. 157).

Albee (1988) points out that

> Reducing stress may require changes in the physical and social environment. Environmental stress situations involve a whole complex of interacting variables. Some forms of social stress are a product of deeply ingrained cultural values and ways of life that are not easily susceptible to change. (p. 20)

For this section of the planning worksheet, the following questions may help:

1. What are the intrapersonal and interpersonal circumstances that may be causing stress in the members of this group?

2. What are the environmental circumstances and conditions that may be causing stress in the members of this group?

Completion of this step will assist in the development of goals, objectives, and procedures for STEP VIII.

STEP IV

LIST THE SOURCES AND KINDS OF EXPLOITATION THAT MAY OCCUR IN THE LIVES OF PEOPLE IN THIS POPULATION.

Exploitation is defined as use or abuse for another's selfish advantage, and in the words of Albee (1988c),

> This factor differs from the others in the formula in an important way. Variations in the degree or type of exploitation affect all the other variables in the model -- stress, coping skills, self-esteem, the nature and type of support groups available, and even the incidence of organic factors. For example, in a society in which a power elite exploits the environment for personal profit without regard to the social costs and consequences of their greed, the incidence of birth defects may be increased by environmental contamination or malnutrition, physical health of workers may be damaged, and so on. Since exploitation encompasses all the other variables, as well as being something that itself, with its many faces, contributes to psychopathology, it needs to be considered in both its larger and its smaller sense. (pp. 20-21)

> Persons who are victims of exploitation in any of its myriad forms suffer serious emotional damage. The exploitation often involves the use of excessive power by the exploiter to force the victims to conform or to behave in ways that are degrading, demeaning, dehumanizing, and/or dangerous. While the experience may well be both stressful and damaging to self-esteem, there is a qualitative difference that justifies separate analysis of this factor. In many societies and throughout the history of many cultures, women and children have been exploited by powerful male patriarchal elites. Rape and sexual abuse of children are obvious examples of exploitation. But there are many other more subtle ways that people can be subject to daily humiliations. (p. 21)

> It is important that we try to learn about a society, or any other group sharing a common culture, those things (like sex roles and class position) taken for granted. What are the unquestioned assumptions, the accepted ways of understanding reality, that never rise above the threshold of conscious awareness because no one feels they can question or examine them? (p. 21)

> Damage done through exploitation -- economic, sexual, through the media, causes increased incidence of emotional pathology. The exploited groups are not responsive to exhortations or to

other quick-fix solutions. Certain kinds of exploitation result in low self-esteem and become a kind of self-fulling prophecy. Members of ethnic minorities and women, who learn from earliest childhood that their race or sex is regarded as inferior by the white patriarchal culture grow up with lower self-esteem that may be exceedingly difficult to change. Feelings of powerlessness are a major form of stress. Preventive efforts may have to take the form of laws to ensure equal opportunity, public education, changes in the way the mass media portrays these groups, and in pervasive value system changes. Clearly, such efforts often encounter the angry resistance of the power forces that get real benefit from the values being criticized. (p. 21)

A reduction in incidence also may be accomplished by developing feelings of competence -- better social coping skills, improved self-esteem, and solid support networks. (p. 21)

The following questions may be of help in addressing the assignment for this step:

1. Under what circumstances are the individuals in the specified group, or the group itself, used and/or abused in their domestic (home) setting?
2. Under what circumstances are the individuals in the specified group, or the group itself, used and/or abused in their school or employment setting?
3. Under what circumstances are the individuals in the specified group, or the group itself, used and/or abused in their community or larger culture?

Completion of this step will assist in the development of goals, objectives, and procedures for STEP VIII.

STEP V

LIST THE SKILLS/ATTITUDES THAT WILL HELP THIS POPULATION COPE WITH, AND GROW IN, THEIR PARTICULAR LIFE SITUATION.

The concern at this step is with identifying behaviors and attitudes that not only help an individual cope (maintain the status quo) in his or her environment but also allow for growth. In the process of completing this step, the group should answer the following questions:

1. What behaviors are necessary for coping and growth in the life situation in which the specified group lives?

2. What attitudes are necessary for coping and growth in the life situation in which the specified group lives?

One may begin by considering the points that Kleinke (1991) makes about coping. For Kleinke (1991), "coping can be defined as the efforts we make to manage situations we have appraised as potentially harmful or stressful" (p. 3), and thus,

> Good copers have developed the following skills (Atonovsky, 1979): (1) flexibility: being able to create and consider alternative plans; (2) farsightedness: anticipating long-range effects of coping; and (3) rationality: making accurate appraisals. (p. 11)

And, he concludes that

> Successful copers respond to life challenges by taking responsibility for finding a solution to their problems. They approach problems with a sense of competence and mastery. Their goal is to assess the situation, get advice and support from others, and work out a plan that will be in their best interest. Successful copers use life challenges as an opportunity for personal growth, and they attempt to face these challenges with hope, patience, and a sense of humor.
>
> Unsuccessful copers respond to life challenges with denial and avoidance. They either withdraw from problems or they react impulsively without taking the time and effort to seek the best solution. Unsuccessful copers are angry and aggressive or depressed and passive. They blame themselves or others for their problems and don't appreciate the value of approaching life challenges with a sense of hope, mastery, and personal control. (Kleinke, 1991, p. 11)

Completion of this step will assist in the development of goals, objectives, and procedures in STEP XI.

STEP VI

LIST THE ACTIONS THAT WILL HELP BUILD THE SELF-ESTEEM OF EACH PERSON IN THIS POPULATION.

Coopersmith (1967) defines self-esteem as

> ...the evaluation which the individual makes and customarily maintains with regard to himself: it expresses an attitude of approval or disapproval, and it indicates the extent to which the individual believes himself to be capable, significant, successful,

and worthy. In short, esteem is a personal judgement of worthiness that is expressed in the attitudes the individual holds toward himself. (p. 5)

In addition, Friedmann and Brooks (1990), in their program entitled BASE (Behavioral Alternatives Through Self-Esteem), present what they call the "self-esteem building blocks" (p. ix) along with definitions of each "block".

Approval
Demonstrated recognition which complements something the child has done or initiated (approval of effort is often as valuable as approval of accomplishment).

Trust
Expression of belief in another's (the child's) honesty. Expression of confidence in the child's sense of maturity or responsibility.

Sense of Power
Knowing that "in this arena", one has superior skills, or (at least) skills equal to anyone else in the same arena. Feeling the collective strength of those with whom one is associated at a given time (a good team, club, gang, etc.).

Acceptance
One's feeling that others appreciate who he or she is, based on What is rather than Who one is (i.e., acceptance/approval of one's character).

Responsibility
The knowledge that one can accept -- and that other's expect one to accept -- duties, morals, and commitments, and, without unnecessary persuasion, accomplishes tasks and behaves "properly".

Self-respect
Internalizes the assurance that one is living up to personal standards and self-expectations (of achievement, morality, trust) to the best of one's ability.

Respect for others
Displaying an appreciation for the "personhood" of others without regard for fashion, status, or ability, but with regard to the fact that we share morality and fallibility.

Flexibility
The ability to hold to standards with steadfastness and discipline, and yet without rigidity. The ability to assess one's

surroundings and make appropriate adjustments in thought and behavior.

Pride
Feeling good about one's self, often because of some accomplishment recognized by respected others.

Self-importance
Feeling that others regard one as a significant contributor to the human experience -- even if recognized for "small" tasks and achievements. (Friedmann & Brooks, 1990, pp. ix-x)

And, referring to this conceptualization of self-esteem, the following questions may be helpful in defining the requested actions:

1. What skills could the individuals in the specified group acquire in order to feel more capable and successful?
2. What social supports could be put into place that would make the specified group feel more significant?
3. What learning experiences could the individual in the specified group have that would enhance their individual and/or collective self-esteem?

Completion of this step will assist in the development of goals, objectives, and procedures in STEP IX.

STEP VII

LIST THE TYPES OF SUPPORT SYSTEMS (GROUPS, FAMILIES, COMMUNITIES, AND INDIVIDUALS), AND SPECIFY THE ROLE OF EACH, IN PROMOTING THE COPING, GROWTH, AND SELF-ESTEEM OF MEMBERS OF THIS POPULATION.

Social support is a vital element in the coping and self-esteem of an individual, and one's ability to develop and grow may depend on the nature of the social support that is present in his or her life. Berkowitz (1982) describes the nature and value of a personal social support network in the following.

> It sustains you, both passively and actively. To start with, it gives you security, just by being there, like money in the bank you never touch. More actively, it provides recognition; you are known as a person. It confers affirmation; you are worthwhile, a valuable person. People in your support system can extend task-oriented assistance ranging from watering the plants when you are away, to providing information on your legal rights, to

> offering cash payments when you are dead broke. They can give you emotional comfort when you need a sympathetic ear, or someone to guide you through a personal crisis. Your support system stimulates your participation in community life, by allowing you to express your competence, and by supplying you with chances to reciprocate the support you have received. And finally, your supports promote personal growth, by making it easier to take risks; you have the backing to try, the encouragement along the way, the approval if you succeed, the cushioning should you fail. (p. 6)

With these qualities, it may be beneficial to assess an individual's or group's social support network before beginning to plan an intervention. The following material is taken from Maguire (1983) and is intended to help in the understanding of networks and to facilitate the process of assessing the social support network of an individual.

> Networks can be analyzed in depth using a wide variety of techniques and analytical variables (Barnes, 1972; Boissevain & Mitchell, 1973; Fischer, et al., 1977; Mitchell, 1969). Some of the more commonly used critical dimensions of dyadic or two-person links in a network include multiplexity, or the number of roles or relations (for example, brother, neighbor, and co-worker) that connect two people; symmetry, or the balance of power or profit; and intensity, or the degree of commitment in a link. Other dimensions of the entire network and its set of links can also be described. For instance, range, which refers to the number of actors connected in a link; density, or the extent of interlinkage among the actors (usually expressed as the ratio of the number of existing links to the number of possible links); reachability, or the average number of links needed to connect any two actors to the shortest route; and clustering, or the extent to which the total network is divided into distinguishable cliques. (p.14)

Maguire (1983) suggests that one way to understand networks is to begin by mapping one's own net work using the following exercise.

> Take a large piece of paper and draw five concentric circles, leaving enough space between each circle to do some writing. Now divide the circles into [five] wedge -- or pie -- shaped sections. Label the sections for each of your major spheres of influence: family and relatives, friends, neighbors, colleagues from work or school, and professional caregivers. (p. 15)
>
> The center is you -- the ego, central figure, or anchor point of your network configuration. Beginning with the circle nearest to the center, write the names or initials of those closest to you

within each sphere of influence. In the first section closest to yourself may be your wife or husband, followed in the second section of that family sphere by your children, parents, and brothers and sisters. The next outlying sections or section may contain in-laws, cousins, aunts, uncles, grandparents, and so on. In this and other spheres, there will often be overlay. For instance, for most of us our friends will sometimes be our work colleagues or neighbors as well. Where possible, limit people to only on sphere. Once you have filled out all the concentric areas in all the spheres, connect the names of people who know each other with lines. This is your network. (p. 15)

If you have many lines between and among your network members, it is a "dense" network. If these linkages are infrequent, it is not dense. If you have direct cross-linkages between many members of different spheres of influence, you have a high degree of "reachability" within the network. The strength of one's network is sometimes assessed as how "close" the network members are to you at the anchor point. (p. 15)

For many, this is a fascinating, revealing, and sometimes surprising exercise. [It has been] used with a wide variety of audiences in workshops, classes, and conferences. [Graduate students] who tend to be predominantly in their twenties, often note that changes in marital status and the presence or absence of children make a significant difference in their networks. (pp. 15-16)

The married students, particularly the older ones, also recognize that their networks become further differentiated on the basis of whether their friends have children or not, a finding that is consistent with other research (Campbell, et al., 1976) showing how networks are often established within one's neighborhood on the basis of friendships among children. Young married students with children frequently note that many of their friendships are with other couples who also have children, particularly if the children are of the same age and sex. Not infrequently, divorced students, both male and female, have commented that their network configuration changed after the divorce and that they reverted back to having many single or divorced friends, rather than married couples. (p. 16)

[Sometimes people have noted] with surprise the high degree of homogeneity among their network of friends in terms of education, income, age, and interests. This is sometimes a shock to white, middle-class, liberal professionals who are forced to recognize that their inner circle of friends rarely includes people of different races or social backgrounds. (p. 17)

> Several other, rather clear patterns emerge from an analysis of networks. For instance, if people live in the same area for all of their lives, they are likely to have more multiplexity in role members, because their closest friends are usually from their old childhood neighborhood as well. In some instances, these network bonds are further strengthened by the fact that cousins, grandparents, aunts, and uncles all live in the neighborhood, and even those neighbors who are not directly related in many instances share the same ethnic, racial, or religious background. (p. 17)

Maguire (1983) also suggests another clinical way in which to analyze the support network of an individual. Begin by creating eight columns on a sheet of paper. Column 1 constitutes the names, addresses, and telephone numbers of persons in the individual's network. Column 2 is entitled "Relationship", and in it, the relationship of the person in Column 1 to the individual being studied is indicated. Column 3 is entitled "Willingness to Help", and here, the willingness of the person in Column to help is rated as "high", "medium" or "low". Column 4 is headed by the worked "Capabilities", and this refers to how able the person in Column 1 is to provide for the social/emotional needs of the individual being studied. Column 5 is entitled "Resources" and refers to what the person in Column 1 can contribute, either materially or in terms of contacts, to the individual being studied. Column 6 is for "Frequency of Contact", and in it, the terms "daily", "weekly", "bi-weekly", "monthly", etc., are used to describe how often the person in Column 1 interacts with the individual being studied. Column 7 refers to "Duration of Friendship", and it serves as a place to indicate, using terms such as "one month", "six months", "one year", "one to five years", etc., the duration of the relationship between the person in Column 1 and the individual being studied. Finally, Column 8 is entitled "Intensity", and it describes the "...degree of potential helpfulness or functionality and the degree of liking or affection that is felt toward the person" (Maguire, 1983, p. 77) in Column 1 by the individual being studied.

Material from a network analysis can be used in developing goals, objectives, and procedures for STEP IX.

In addition, in looking toward STEP IX, there are numerous types of social supports that will enhance the lives of people, and Gottlieb (1983) provides a very thorough description of these in Table 4. These represent supportive behaviors that can be supplied to individuals through one-on-one or through group interactions. They also represent behaviors that can be taught to individuals and when displayed will elicit reciprocal support from others.

Table 4
A Classification Scheme of Informal Helping Behaviors

CATEGORY	DEFINITION	EXAMPLE
A. EMOTIONALLY SUSTAINING BEHAVIORS		
A1. Talking (unfocused)	Airing or ventilation of general concerns without reference to problem specifics	"she'll talk things over with me"
A2. Provides reassurance	Expresses confidence in R as person, in some aspect of R's <u>past</u> or <u>present</u> behavior, or with regard to the future course of events	"he seems to have faith in me"
A3. Provides encouragement	Stimulates or motivates R to engage in some <u>future</u> behavior	"she pushed me a lot of times when I was saying 'oh, to heck with it'"
A4. Listens	Listening only, without reference to dialogue	"he listens to me when I talk to him about things"
A5. Reflects understanding	Signals understanding of the facts of R's problem or of R's feelings	"she would know what I was saying"
A6. Reflects respect	Expresses respect or esteem for R	"some people look down on you; well, she doesn't"
A7. Reflects concern	Expresses concern about the importance or severity of the problem's impact on R or for the problem itself	"just by telling me how worried or afraid she is" (for me)
A8. Reflects trust	Reflects assurance of the confidentiality of shared information	"she's someone I trust and I knew that it was confidential"
A9. Reflects intimacy	Provides or reflects interpersonal intimacy	"he's just close to me"
A10. Provides companionship	Offers simple companionship or access to new companions	"I've always got her and I really don't feel alone"

A11. Provides accompaniment in stressful situations	Accompanies R in a stressful situation	"she took the time to be there with me so I didn't have to face it alone"
A12. Provides extended period of care	Maintains a supportive relationship to R over what R considers an extended period of time	"she was with me the whole way"
B. PROBLEM-SOLVING BEHAVIORS		
B1. Talking (focused)	Airing or ventilation of specific problem details	"I'm able to tell him what's bugging me and we discuss it"
B2. Provides clarification	Discussion of problem details which aims to promote new understanding of new perspectives	"making me more aware of what I was actually saying other than just having the words come out"
B3. Provides suggestions	Provides suggestions or advice about the means of problem solving	"he offered me suggestions of what I could do"
B4. Provides directive	Commands, orders, or directs S about the means of problem solving	"all Rose told me was to be more assertive"
B5. Provides information about the source of stress	Definition same as category name	"she keeps me in touch with what my child's doing"
B6. Provides referral	Refers R t alternative helping resource(s)	"financially, he puts me on to a car mechanic who gave me a tune-up for less than I would pay in a garage"
B7. Monitors directive	Attempts to ensure that R complies with problem-solving directive	"making sure that I follow through with their orders"
B8. Buffers S from source of stress	Engages in behavior which prevents contact between R and stressor	"he doesn't offer it (alcohol) to me anymore"

B9. Models/provides testimony of own experience	Models behavior or provides oral testimony related to the helper's own experience in a similar situation	"just even watching her and how confident she seems has taught me something"
B10. Provides material aid and/or direct service	Lends or gives tangibles (e.g., food, clothing, money) or provides service (e.g., babysitting, transportation) to R	"he brought his truck and moved me so I wouldn't have to rent a truck"
B11. Distracts from problem focus	Temporarily diverts R's attention through initiating activity (verbal or action-oriented) unrelated to the problem	"or he'll say, 'Let's go for a drive"...some little thing to get my mind off it"
C. INDIRECT PERSONAL INFLUENCE		
C1. Reflects unconditional access	Helper conveys an unconditional availability to R (without reference to problem-solving actions)	"she's there when I need her"
C2. Reflects readiness to act	Helper conveys to R readiness to engage in future problem-solving behavior	"he'll do all he can do"
D. ENVIRONMENTAL ACTION		
D1. Intervenes in the environment to reduce source of stress	Intervenes in the environment to remove or diminish the source(s) of stress	"she helped by talking to the owners and convincing them to wait for the money a while"

Source: Gottlieb, B.H. (1983). Social support strategies: Guidelines for mental health practice. Beverly Hills, CA: Sage, pp. 54-56.

The task in this section is to determine the types of social supports that will be most beneficial to the specified population, and a review of the possibilities in Table 4 may help with this.

At times, the use of formal or informal support or mutual self-help groups may be appropriate. A general review of how to develop and facilitate support groups is contained in Dickel (1987). In addition, suggestions for support groups for teachers is found in Boytim and Dickel (1990). Completion of this step will assist in the development of goals, objectives, and procedures in STEP IX.

STEP VIII

SPECIFY TWO GOALS AND ACCOMPANYING OBJECTIVES FOR EACH OF THE FOLLOWING: (1) DECREASING THE ORGANIC FACTORS IN THIS POPULATION, (2) REDUCING THE STRESS FACTORS IN THIS POPULATION, AND (3) ELIMINATING THE EXPLOITATION IN THIS POPULATION. IN ADDITION, SPECIFY THE PROCEDURES THAT WILL BE USED TO ACHIEVE EACH GOAL AND OBJECTIVE.

The following questions appear on the planning form and provide the basis for this step:

1. What behaviors or environmental circumstances can be changed, and in what way, in order to decrease the likelihood of disease or the physical wear and tear on the bodies of the people in this group?
2. What behaviors or environmental circumstances can be changed, and in what way, in order to decrease the likelihood of stress in the individuals in this group?
3. What behaviors or environmental circumstances can be changed, and in what way, in order to decrease the exploitation of members of this group?

STEPS II, III, IV were completed with the intention of providing material to assist in the development of the goals, objectives, and procedures for this step.

STEP IX

SPECIFY TWO GOALS AND ACCOMPANYING OBJECTIVES FOR EACH OF THE FOLLOWING: (1) INCREASING THE COPING SKILLS OF THIS POPULATION, (2) BUILDING SELF-ESTEEM OF MEMBERS OF THIS POPULATION, AND (3) DEVELOPING APPROPRIATE SUPPORT GROUPS FOR THIS POPULATION. IN ADDITION, SPECIFY THE PROCEDURES THAT WILL BE USED TO ACHIEVE EACH GOAL AND OBJECTIVE.

The following questions appear on the planning form and provide the basis for this step:

1. What skills and attitudes can be developed in individuals in this population that will enable them to cope and grow in their life circumstance?
2. What can be done with individuals in this population to increase their positive evaluation of self?

3. What can be done to build a supportive network for each individual in this population?

STEPS V, VI, and VII were completed with the intention of providing material to assist in the development of the goals, objectives, and procedures for this step.

STEP X

EXPLICATE A STRATEGY FOR THE EVALUATION OF THIS PRIMARY PREVENTION PLAN AND FOR FOLLOW-UP WITH MEMBERS OF THIS POPULATION

The current shortage of funds for most social service and preventive programs makes the ability of those programs to prove their effectiveness an absolute necessity, and the final step to planning is the development of a strategy by which the outcome of the prevention intervention can be evaluated. Whether the concept is "outcome-based intervention" or the old idea of "accountability", no plan is complete unless provisions are made to demonstrate effectiveness.

Compas, Phares, and Ledoux (1989) present the following table which has been abbreviated for this manual. These authors provide examples of outcome criteria for stress and coping interventions by citing the outcome/evaluation criteria of others.

Table 5
Examples of Outcomes and Evaluation Criteria

STUDY	SAMPLE	DESIRED OUTCOME	EVALUATION
Bogat, Jones, & Jason (1980)	1st through 7th grade students (n=56)	Promotion of knowledge and self-esteem	Increased social self-esteem, increased knowledge about school setting, improved school conduct
Elias, et al. (1986)	5th grade students (n=158)	Prevention of stress and promotion of coping skills	Fewer and less intense stressful events, enhanced coping skills

Felner, Ginter, & Primavera (1982)	9th grade students (n=172)	Prevention of absenteeism, promotion of self-esteem and academic performance	Maintenance of self-esteem, grades, school attendance, and positive perceptions of school environment
Felner, Norton, Cowen, & Farber (1981)	School age children (unspecified)	Prevention of behavior problems and enhancement of school adjustment	No controlled evaluation data
Pedro-Carrol & Cowen (1985)	3rd through 6th grade students (n=75)	Prevention of behavior problems and enhancement of self-esteem and school adjustment	Reduction in behavior problems and improved school adjustment
Pedro-Carroll et al. (1986)	4th through 6th grade students (n=132)	Prevention of behavior problems and enhancement of perceived control and school adjustment	Reduction in behavior problems and improved school adjustment
Stolberg & Garrison (1985)	7-13 year olds and their mothers (n=82)	Reduced behavior problems and stress, enhanced self-esteem	Children and mothers showed improvement varying with type and intervention
Zaichkowsky & Zaichkowsky (1984)	4th grade students (n=43)	Reduced anxiety	Improved control over anxiety

Source: Compas, B.E., Phares, V., & Ledoux, N. (1989). Stress and coping preventive interventions of children and adolescents. In L.A. Bond & B.E. Compas (Eds.), Primary prevention and promotion in the schools (pp. 319-340). Newbury Park, CA: Sage.

The effectiveness of a plan can be observed at numerous levels, and using a school situation as an example, Lorion (1983) points out that there can be an

...impact at a number of potential levels, including:

> direct individual effects on children (e.g., improved reading)
>
> direct individual effects on teachers (e.g., improved attitudes toward teaching)
>
> direct individual effects on parents (e.g., fewer school-related confrontations with children)
>
> interactional effects among the dyadic and triadic pairs of these individuals (e.g., parents and teachers, children and parents and teachers)
>
> indirect effects on the interpersonal contacts of the children, parents, and teachers (e.g., family impacts for teachers; effects of parent impacts on siblings of target child)
>
> direct system effects (e.g., changes in teacher assignment pattern, demand for special education services, policy considerations relevant to the link between service and demand, reduced need, and special education personnel utilization)
>
> indirect system effects (e.g., the program's impact on curriculum planning in subsequent grades, requisite shifts in special education personnel at upper grades, alterations in the timing and success potential of mainstreaming decisions) (p. 262)

Obviously, any intervention can have individual, interpersonal, institutional, and/or system impact, and the question for evaluation is,

> How will the members of the specified population be different following the full implementation of this primary prevention plan?

In addition, the planner(s) may want to consider changes in interpersonal relations, changes in the institution, and changes in the system of which the institution is a part, all as a result of the implemented intervention.

Lastly, there is a need to develop a follow-up plan for this intervention. Once the intervention is complete, the question remains

> How will the changes that result at all levels continue to remain in existence?

The concern is with providing periodic evaluation, motivation, and re-training that will insure the continuing effects of the original intervention. It could be that the changes will immediately become ingrained, but more than likely, they will need help with becoming established. At specified intervals following the initial intervention, the planning team should re-evaluate the changes that have occurred and be prepared with strategies to further establish the desired changes.

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Sample Worksheet

TEAM PLANNING FOR PREVENTIVE MENTAL HEALTH INTERVENTIONS

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The following prevention exercise is based on the incidence formula of George Albee and is intended to help communities reach a concensus on how to prevent emotional disturbance, stress-related problems, and/or behavior disorders in subgroups within the community. The Albee (1982) formula states that

$$\text{Incidence} = \frac{\text{Organic Factors} + \text{Stress} + \text{Exploitation}^*}{\text{Coping Skills} + \text{Self-Esteem} + \text{Support Groups}}$$

*** In Albee (1985), "exploitation" is added to the original formula.**

STEP I: Describe in writing the population for whom you wish to plan a prevention intervention.

STEP II: List the organic factors (illnesses, health habits, etc.) that can play a role in causing emotional or behavioral problems in this population.

STEP III: List the social and environmental stress events and circumstances that are likely to impinge on the lives of people in this population.

STEP IV: List the sources and kinds of exploitation that are likely to occur in the lives of people in the population.

Source	Kind

STEP V: List the skills that will help this population cope with, and grow in, their particular life situation (some of these skills may be attitudes).

STEP VI: List the actions that will help build the self-esteem of each person in this population.

STEP VII: List the types of support systems (groups, families, communities, and individuals), and specify the role of each, in promoting the coping, growth, and self-esteem of members of this population.

Support System	Role

STEP VIII: Specify two goals and accompanying actions for each of the following: (1) decreasing the organic factors in this population, (2) reducing the stress factors in this population, and (3) eliminating the exploitation in this population. In addition, specify the procedures that will be used to achieve each goal and objective.

1. Decreasing organic factors (What can be done to eliminate the illnesses, illness producing behaviors, etc. that cause this population difficulties?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

2. Reducing the stress factors (What can be done to reduce or eliminate the stressors that cause problems for this population?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

3. Eliminating the exploitation (What are the sources of use and/or abuse in this population, and how can these be eliminated?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

STEP IX: Specify two goals and accompanying objectives for each of the following: (1) increasing the coping skills of this population, (2) building the self-esteem of members of this population, and (3) developing appropriate support groups for members of this population. In addition, specify the procedures that will be used to achieve each goal and objective.

1. Increasing the coping skills of this population(What new behaviors/abilities would help individuals in this population better manage themselves under stress?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

2. Building the self-esteem of members of this population (What can be done with the individual in this population to increase his/her positive evaluation of self?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

3. Developing appropriate support groups for members of this population (What can be done to build a supportive network for each individual in this population?):

Goal:

Objective:

Objective:

Goal:

Objective:

Objective:

Procedures:

STEP X. Specify how you will evaluate the success of this intervention program and how you will follow-up with members of this population..

GLOSSARY

COPING SKILLS = social and cognitive abilities that enable an individual to deal with life's problems and, as a result, "...reduce an incidence of frustration and emotional disturbance" (Albee, 1982, p.1047).

EXPLOITATION = used and abused for another's selfish advantage.

ORGANIC FACTORS = disease states, disease causes, or behaviors that contribute to disease or illness (e.g., smoking, drinking of alcoholic beverages, poor nutrition, excessive caffeine, drug abuse, poor sleeping habits, etc.).

PRIMARY PREVENTION = a movement within psychology and mental health that "...emphasizes the reduction of unnecessary stress, including powerlessness, and the enhancement of social competence, self-esteem, and support networks" (Albee, 1982, p.1043).

SELF-ESTEEM = an individual's level of valuing of him/herself. This can be positively influenced by a person's coping abilities and his/her support system.

STRESS = sources of threat, feelings of powerlessness, and excessive demand on personal resources. Reduction of stress "...requires changes in the physical and social environment" (Albee, 1982, p.1046).

SUPPORT GROUPS = those individuals, and/or informal and formal groups of individuals, who comprise a person's external source of self-esteem, coping, and growth.

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